Los Angeles County:

The Department of Children and Family Services Can Improve Its Processes To Protect Children From Abuse and Neglect

October 1996
96106

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October 23, 1996 96106

The Governor of California
President pro Tempore of the Senate
Speaker of the Assembly
State Capitol
Sacramento, California 95814

Dear Governor and Legislative Leaders:

As requested by the Joint Legislative Audit Committee, the Bureau of State Audits presents its audit report concerning the Los Angeles County Department of Children and Family Services (DCFS) and its administration of child protective services within Los Angeles County. This report concludes that the DCFS does not always comply with its own risk assessment policies. In some cases, the DCFS did not prepare risk assessment documents, or the documents were inadequately prepared. In addition, the risk assessment method used by the DCFS does not appear to be the best method available. It is not based on a study of actual cases and, therefore, may be less able to predict future child abuse or neglect than the risk assessment methods used in other states. Finally, we found that the DCFS does not always comply with other child safety procedures, such as monthly visits, criminal background checks, and timely medical assessments of children.

Respectfully submitted,

Kurt Sjoberg

KURT R. SJOBERG
State Auditor

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Summary

Audit Highlights . . .

The Los Angeles County Department of Children and Family Services:

- ☑ ***Does not always comply with its own policies to evaluate the potential risk to a neglected or abused child;***
- ☑ ***Needs to revise its risk assessment method; and***
- ☑ ***Does not always comply with other child safety procedures, such as monthly visits, criminal background checks of caregivers, and timely medical assessments of children.***

Results in Brief

The Los Angeles County (L.A. County) Department of Children and Family Services (DCFS) began operation on December 1, 1984, consolidating the county's Department of Adoptions and the children's services functions of the Department of Public Social Services. The DCFS is devoted exclusively to ensuring that children are safe from abuse, neglect, and exploitation by establishing, managing, and advocating a system of services to children and their families. In general, when incidents of abuse, neglect, or exploitation are assessed by the DCFS to be actually or imminently dangerous to children, it detains the children and seeks the legal oversight of the Superior Court. In L.A. County, the Juvenile Division of the Superior Court (dependency court) is responsible for supervising such cases, commonly called "dependency" cases. The dependency court relies on the DCFS to provide it with the relevant facts and evidence, as well as to provide court-ordered services. In over 98 percent of L.A. County hearings, the dependency court agrees with the recommendations of the DCFS.

Our review focused on the DCFS and its child safety policies and procedures. Specifically, we noted the following concerns:

- The DCFS does not always comply with its own risk assessment policies. For 6 of 24 cases we reviewed, the risk assessment documentation was either missing, incomplete, or inadequately prepared. In addition, the risk assessment method used by the DCFS does not result in a standardized risk rating and, thus, it has less assurance that the most intense services are given to the most at-risk cases. Finally, when compared to different risk assessment methods used in some other states, the DCFS's method does not appear to be the best available.

- The DCFS does not always comply with other child safety procedures. In particular, we found it does not always follow its own policy to visit children and their parents or caregivers once per month. Also, we noted that required criminal background checks on adults caring for children were not always obtained by the DCFS. Finally, we found

that children's medical assessments were not obtained in a timely manner and required reports were not submitted to the court on time.

Recommendations

To improve its method of assessing risks to children, the DCFS should investigate developing a new, actuarial-based risk assessment method. Such a method should be standardized to ensure the method is applied consistently with DCFS policies and procedures and consistent results are achieved. The DCFS should also periodically evaluate the reliability and validity of the method.

To protect the safety of the children who are referred to it because of suspected abuse or neglect, the DCFS should follow its child safety policies and procedures. Specifically, it should take the following steps:

- Ensure that it visits children and their parents or caregivers a minimum of once each calendar month. If safety or risk conditions indicate, the DCFS should consider more frequent visits.

- Obtain criminal identification investigation clearances when required.

- Ensure that medical examinations are obtained within required time limits and complete and appropriate medical attention is obtained in a timely manner when injuries to children are noted.

- Submit its completed reports so they can be available to the court 48 hours prior to the hearing date.

Agency Comments

In its response to our audit report, the DCFS asserts that we inappropriately focused our audit work on its activities and not on adverse judicial decisions made by the dependency court. Further, it did not agree with our recommendation that it develop a new, actuarial-based risk assessment method. In addition, although it did not disagree with our recommendations that it should follow its child safety policies and procedures, it noted that its current level of compliance surpasses that of many

other California counties. Finally, the DCFS expressed concerns that our sample of 24 case files was too small to support our recommendations.

The L.A. County Superior Court believes that our report was thorough and accurate.

Introduction

Established on February 18, 1850, Los Angeles County (L.A. County) covers 4,083 square miles located in the southern coastal portion of California. L.A. County is one of the State's original 27 counties and in 1995 had a population of 9.2 million people. In terms of population, L.A. County is the largest in the United States and is larger than 42 states. One of the major departments within the L.A. County government is the Department of Children and Family Services (DCFS).

Beginning operation on December 1, 1984, the DCFS consolidated L.A. County's Department of Adoptions and the children's services functions of the Department of Public Social Services into one department devoted exclusively to serving children and their families.

Children are referred to the DCFS through its child abuse hotline. Any person can report suspected child abuse or neglect. Referrals are commonly made by teachers, doctors, and other health care professionals, who are mandated by law to report suspected cases of child abuse or neglect.

The hotline worker who responds to the call determines whether the situation warrants an in-person investigation. If an investigation is necessary, a DCFS emergency response worker is assigned to the case and conducts it. The hotline received approximately 128,000 calls in 1995, which resulted in the DCFS conducting in-person investigations involving approximately 166,000 children.

Depending on the results of the investigation, the DCFS may offer services such as counseling and parenting classes to assist the family to alleviate problems. In situations where the DCFS believes a high risk of future abuse or neglect exists, a child may be detained, that is, placed in protective custody.

When a situation is serious enough to warrant the detention of a child, the DCFS is required by statute to seek the legal approval of the Juvenile Division of the L.A. County Superior Court (dependency court). The dependency court conducts hearings to determine whether continued detention is necessary and, if it is, makes the child a dependent of the court. During the initial hearings and throughout the dependency court's jurisdiction,

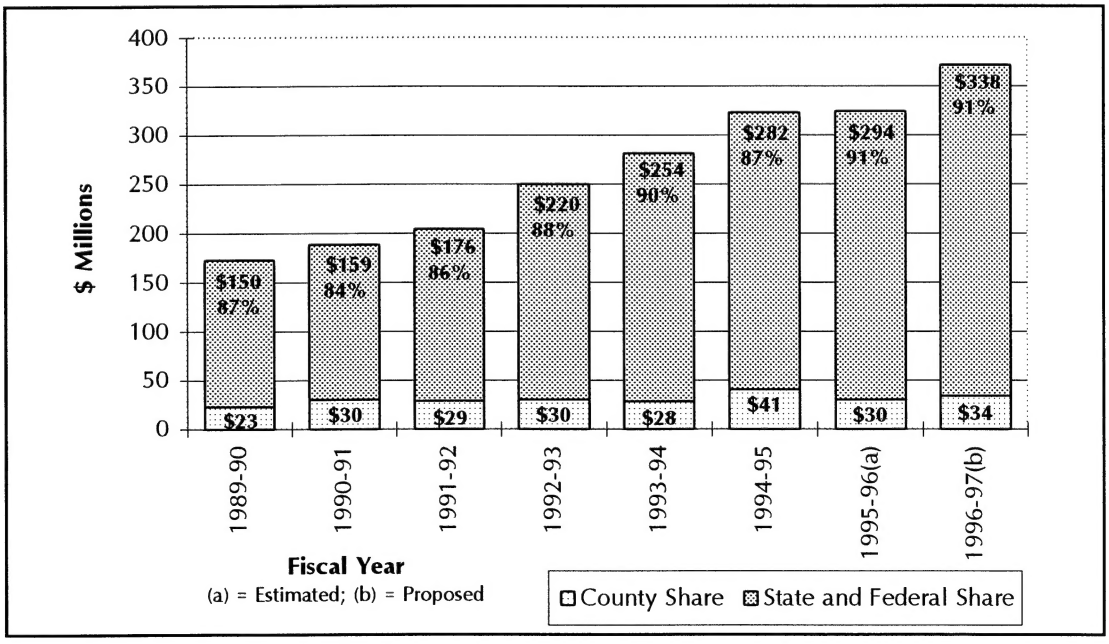
the DCFS is required to provide recommendations as well as information and evidence necessary to oversee the case. The dependency court independently evaluates the information, evidence, and recommendations and issues its orders. In approximately 98 percent of the hearings, the court agrees with the recommendations of the DCFS. Included in its orders, the dependency court charges the DCFS to provide certain services to the child and family. These include family reunification services, discussed below.

Overview of DCFS Operations

The DCFS is organized into seven regions within L.A. County. As illustrated in Figure 1, its budget has increased from $173 million in fiscal year 1989-90 to a proposed budget of $372 million for fiscal year 1996-97. L.A. County receives state and federal funds based on caseload and performance measures. The amount of total funds provided by the state and federal governments ranged from 84 to 91 percent during the last eight years.

Figure 1

Funding for the DCFS—L.A. County vs. State and Federal Funding

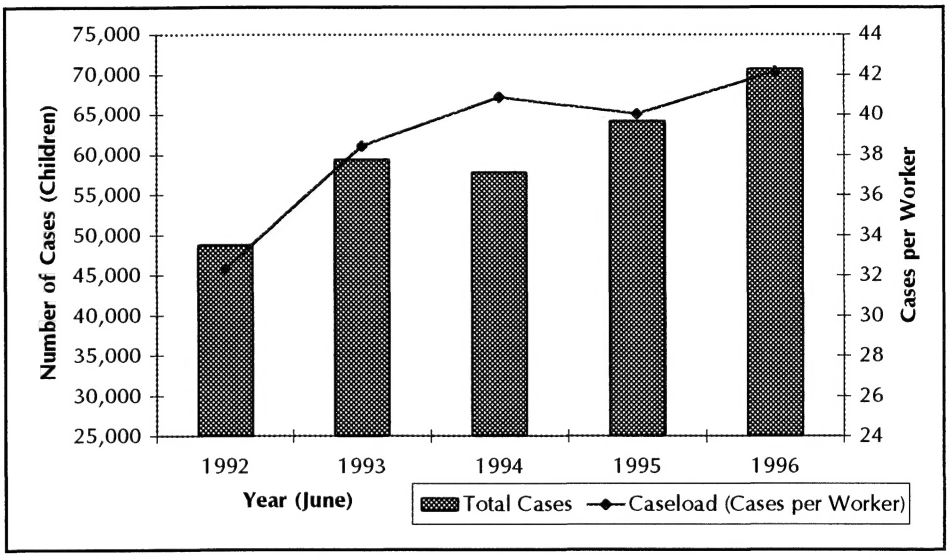


Source: L.A. County Budget

As illustrated in Figure 2 below, the number of cases within the DCFS system has increased from 48,700 in June 1992 to 70,600 in June 1996. During the same period, the number of cases per worker, on average, has increased from 32.2 to 42.1.

Figure 2

Caseload Information for the DCFS



Source: DCFS (Unaudited)

The DCFS's mission, as published in the L.A. County Budget, is as follows:

> To establish, manage, and advocate a system of services, in partnership with parents, relatives, foster parents, and community organizations, which ensures that: children are safe from abuse, neglect, and exploitation; families who can provide a safe home environment for children are respected and strengthened; children whose families are unable to provide a safe home environment are provided temporary homes which support optimum growth and development; children in temporary homes receive safe, secure, nurturing, and stable permanent homes in a timely manner; and youth who reach adulthood under DCFS's care are provided the opportunity to succeed.

To fulfill its mission, the DCFS provides various types of services:

- **Emergency response** services are the initial intake of referrals. Emergency response workers then evaluate those referrals and determine if an in-person investigation is necessary.

- **Family maintenance** provides support services to prevent abuse or neglect while the child remains at home. Generally, these services include counseling, parent training, respite care, and temporary in-home care.

- **Family reunification** provides support services to the abusive or neglectful family while the child is in temporary foster care or other out-of-home placement. Typically, these services are intended to modify the home environment through family counseling, drug counseling, emergency shelter care, parent training, and teaching homemaking skills.

- **Permanent placement** provides management and placement services to children in foster care who cannot be returned to their families.

Overview of the L.A. County Dependency Court

The California Welfare and Institutions Code, Section 300, provides that under certain circumstances, a child shall be placed under the legal jurisdiction of the Superior Court. In general, children who are currently being physically, sexually, or emotionally abused; neglected or exploited; or are at serious risk for such abuse or neglect would be placed under Superior Court supervision. In L.A. County, the dependency court is responsible for supervising such cases, commonly called "dependency" cases.

The dependency court currently consists of 18 operating courtrooms—17 located at the Edmund D. Edelman Children's Court and 1 located at the Lancaster Courthouse. The Lancaster dependency court serves only the families and children in the Antelope and Santa Clarita Valleys.

As explained above, when incidents of abuse and neglect are assessed to be actually or imminently dangerous to children, the DCFS detains children and petitions the dependency court to protect the children through the dependency court's legal

authority. The dependency court relies on the DCFS to provide it with the relevant facts and evidence, as well as to provide court-ordered services and monitor compliance with its orders. Once a child is under its jurisdiction, the dependency court conducts a series of hearings and case reviews that may result in long-term foster care, legal guardianship, adoption, or a return of the child to the family.

The dependency court system provides three separate "pools" of attorneys that represent the parties to each case in court. The L.A. County Counsel (county counsel) always represents the DCFS. Generally, as of January 1, 1996, an organization known as Dependency Court Legal Services (DCLS) represents all of the children in the dependency court. The DCLS is a consortium of three private firms, which allows for the representation of several parties on the same case. The dependency court also provides a "panel" of individual attorneys (panel attorneys), about ten per courtroom, who represent the parents and any other children the DCLS cannot represent.

Actions Taken When the DCFS and Court Disagree

Overall, the dependency court agrees with the DCFS's recommendations in approximately 98 percent of court hearings. We noted that additional safeguards exist to protect children's safety in the cases where the dependency court disagrees with the DCFS. Such cases are called "adverse decisions" by the DCFS and its legal representative, the county counsel. Adverse decisions totaled 546 in 1995 and 1,557 for the first seven months of 1996, out of 153,700 and 96,100 court hearings for the same periods, respectively.

When the DCFS, in consultation with the county counsel, believes that an adverse decision by the court places a child's safety in jeopardy, the DCFS may instruct the county counsel to exercise various legal remedies available in an attempt to overturn the dependency court's adverse decision. These legal remedies include requesting the dependency court to reconsider its decision, requesting that a judge rehear a case previously decided by a commissioner or referee, or appealing a court's decision to the California Court of Appeals.

According to verbal information supplied to us by the county counsel staff, less than 40 percent of adverse decisions represent cases where a child's safety may be jeopardized by the court's adverse decision. We made several attempts, including a written request on September 23, 1996, to obtain confirmation

of this information. In addition, we requested that the county counsel quantify its specific legal actions taken in response to adverse decisions and the results of such actions, that is, how frequently adverse decisions were overturned.

At the time of the completion of our audit, we still had not received the information we requested from the county counsel. As a result, we were unable to determine how frequently the county counsel pursues the legal remedies available to protect children's safety in cases where the dependency court disagrees with the DCFS.

Scope and Methodology

The Bureau of State Audits was requested by the Joint Legislative Audit Committee to perform a review of the child protective service activities within L.A. County and to review the facts surrounding one child death case in 1995. The purpose of this audit was to evaluate the policies and procedures used to protect the children from abuse, neglect, or exploitation. To avoid disclosing confidential and sensitive information for a single child death case, we expanded our review to include 12 child death cases that involved the DCFS and 12 cases selected at random. As a result, our audit was limited to a review of case files for 24 children who had been referred to the DCFS and for which the DCFS investigated allegations of abuse, neglect, or exploitation.

To gain an understanding of the overall child protection system in L.A. County, we reviewed applicable laws, regulations, and other background information. While many public agencies, including law enforcement, medical institutions, and public schools, may share responsibility for protecting children, our initial review indicated that the DCFS and the dependency court have the primary responsibility for seeking and enforcing such protection. The DCFS was an active participant in all 12 child death cases we reviewed, whereas the dependency court was not. As a result, our review emphasized the DCFS and its handling of the cases of the 24 children who had been referred to it.

To gain an understanding of the dependency court system and its responsibilities, we reviewed applicable sections of the Welfare and Institutions Code, California Rules of Court, and the dependency court's own policies and procedures. Additionally, we interviewed judicial officers, court administration staff, and attorneys from the county counsel, DCLS, and court-appointed panel.

To gain an understanding of the DCFS's responsibilities and the environment in which it operates, we reviewed applicable laws, rules, regulations, and its own policies and operating procedures. In addition, we interviewed appropriate personnel and analyzed background material.

We focused our audit efforts and recommendations on the DCFS because the dependency court system relies almost exclusively on information provided by the DCFS, and the court follows the DCFS's recommendations in an overwhelming majority (approximately 98 percent) of cases. To gain an understanding of the actions taken by the DCFS when its recommendations were not accepted by the dependency court, we discussed the various legal remedies, such as requests for rehearings, or appeals to a higher court, with the county counsel.

To determine whether the DCFS complied with its own policies and procedures, which are designed to protect children, we reviewed the case files for 24 separate children. These included the 12 cases for children who were within L.A. County's child protective services system and died during 1995. The remaining 12 cases were chosen at random.

Chapter 1

The Department of Children and Family Services Can Improve Its Risk Assessment of Children

Chapter Summary

Our review of safety policies and procedures revealed two conditions that demonstrate the Department of Children and Family Services (DCFS) can improve its risk assessment of children. First, it does not always comply with its own risk assessment policies. In some cases, the DCFS did not prepare risk assessment documents or only partially completed the documents.

Second, the DCFS's current method of risk assessment does not appear to be the best method available. It is subjective in nature and does not result in a standardized, overall risk rating (such as low, medium, or high) to assist in decision making. In addition, the current method of risk assessment is not based on a study of actual cases and, therefore, has limited assurance that it can predict future child abuse or neglect. Several research studies indicate that risk assessment methods exist which are more objective and more accurate predictors of risk.

Because the DCFS does not always follow its risk assessment policies, it has less assurance that it fully understands the conditions that place a child at risk of future maltreatment. In addition, because its method of risk assessment does not appear to be the best method available, the DCFS has less assurance that the decisions made concerning a child's risk are accurate and reliable.

The DCFS Does Not Always Comply With Its Own Risk Assessment Policies

We found six examples in the 24 children's case files we reviewed where the DCFS did not properly assess risks to the children. Three problems were noted in the cases we selected at random, and three problems were noted in the cases related to child deaths in 1995. We believe that this even distribution of problems between the random cases and the child death cases in 1995 indicates risk assessment problems are not

exclusive to child death cases. We also believe the problems we noted are an indication that the DCFS's current method of risk assessment is not used consistently by its caseworkers.

The California Welfare and Institutions Code, Section 16500, et seq., requires the California Department of Social Services (CDSS) to regulate, in consultation with counties, child welfare services. CDSS regulations require that L.A. County social workers initially investigating a referral shall determine the potential for or the existence of any condition(s) which places the child, or any other child in the family or household, at risk and in need of services. DCFS policy states that throughout the life of a child welfare services case, its focus remains on ensuring that a wide range of parenting practices provides a sufficient level of care for children. The cornerstone of this focus is risk assessment, which is intended to be continuous and ongoing. DCFS policy also states that it is crucial that the caseworker document the specifics of any actions in an accurate and timely way, and that the use of a form, called a risk assessment guide, is essential. Caseworkers are required to determine the level of risk to a child and complete a risk assessment guide. DCFS policy also requires that the caseworker interview all children in a home when investigating allegations of abuse or neglect.

Risk assessment is defined as determining the likelihood of future maltreatment.

Risk assessment, in the context of child protective services, is defined as determining the likelihood of future negative events, such as abuse or neglect (also referred to as "maltreatment" by the Child Welfare League of America). The DCFS currently has a risk assessment guide consisting of 16 factors for which its caseworker assigns a risk rating of low, medium, or high. Table 1 contains a list of the 16 risk factors from the DCFS's risk assessment guide. According to DCFS policy, when used correctly, the risk assessment guide provides a structured method of looking at information and evaluating risk.

Six of the Reviewed Cases Had Inadequate Risk Assessments

We reviewed DCFS and dependency court files for 24 separate child abuse or neglect cases. Twelve of the cases were randomly selected and the other 12 were the child death cases in 1995. In 6 of the 24 cases, the risk assessment guides were incomplete or missing entirely. Three of these were from the randomly selected group, and three were from the group of 12 child death cases.

Table 1

Risk Factors Used by the L.A. County DCFS

1. Child's age, physical and mental abilities
2. Severity and frequency of abuse, physical or sexual
3. Severity, recentness, and frequency of neglect
4. Location of injury
5. School problems
6. Caretaker's physical, intellectual, or emotional abilities
7. Caretaker's level of cooperation
8. Caretaker's parenting skills and knowledge
9. Presence of a parent substitute in the home
10. Previous history of abuse/neglect
11. Strength of family support systems
12. Perpetrator's access to child
13. Environmental condition of the home
14. Stresses/crises
15. Substance abuse (drug/alcohol)
16. Other, explain

In 6 of 24 cases, the risk assessments were incomplete or missing entirely.

In one of the child death cases, we found that the DCFS did not assess the risk on all the children in the home. Although, through its emergency response referral for this case, the DCFS removed the child from the home, it did not assess the four-year-old sibling, who was left in the home.[1] Since both children were less than five years old, the DCFS risk assessment guide defined both as "high-risk" children. While the DCFS may have decided not to detain the sibling, it should have completed a risk assessment guide for the child. This would have provided a basis for its decision and a means to "continuously" assess risk within the household.

In 2 of the other 11 child death cases in 1995, a risk assessment guide was never prepared.

We also noted problems with the risk assessments for 3 of 12 cases we selected at random. In one case, the DCFS recommended visits between a mother and child without ensuring that another adult, who had previously lived in the mother's home and allegedly sexually abused the child, did not have further access to the child. In this case, the child had been removed from the mother's home and the dependency court ordered, based on the DCFS's recommendation, periodic visits between the mother and the child. The dependency court also issued a restraining order to prevent any future contact

[1] After the referred child's death, the sibling was detained by the DCFS. A police report indicated that the sibling had bruises, which could be evidence of prior physical abuse.

between the adult who allegedly abused the child and the mother or the child. The DCFS, however, did not visit the mother's residence to determine whether this adult still lived in the home. As a result, we believe that the DCFS did not adequately assess the safety risks for the child.

In a second case, the DCFS did not properly assess the risks in response to abuse allegations made by a 15-year-old child. When the child contacted the DCFS, she reported that she feared parental retribution and that she did not want her parents to know she contacted the DCFS. The caseworker, however, interviewed the child in the presence of the mother. Not only was the caseworker noncompliant with the child's request, but DCFS policy requires that each child alleged to be a victim of abuse shall be interviewed alone in private.

When risk assessments are not consistently prepared, there is less assurance that children are protected from future maltreatment.

Finally, in one of the remaining ten non-death cases we reviewed, a risk assessment guide was only partially completed.

The problems we noted above indicate that the DCFS's risk assessment method, which is intended to assist caseworkers to evaluate the risk of further maltreatment, is not consistently followed. Moreover, when the DCFS does not prepare a risk assessment guide or does not adequately document its risk assessment, it has less assurance of discovering the potential for future maltreatment.

The DCFS's Risk Assessment Method Does Not Appear To Be the Best Available

Based on our review of several research studies and the risk assessment methods used in some other states, we determined the risk assessment method currently used by the DCFS does not appear to be the best available. Because it is subjective in nature, the current method does not result in a standardized, overall risk rating, such as low, medium, or high. As a result, the DCFS has less assurance that it is consistently giving the most intense services to the cases most at risk. In addition, because its current risk assessment method is not based on a study of actual cases, the DCFS has limited assurance that it can predict future child abuse or neglect.

The Child Welfare League of America, in its *Standards for Service for Abused or Neglected Children and Their Families*, states that "an initial assessment should determine whether the situation or condition of the child requires a child protective service intervention, or whether some

other child welfare service may be better suited. Throughout a child protective service process, including the initial phase of evaluating a report and assessing the level of risk of harm to a child, the agency social worker should be guided by a standardized risk assessment method."

Research indicates that actuarial-based risk assessments are typically more accurate than consensus-based methods.

We reviewed several research publications related to risk assessment, including information presented at the National Roundtable on Child Protective Service (CPS) Risk Assessment.[2] This research identified two general ways of developing a standardized risk assessment method. The first is called the "consensus-based" method. These methods are typically developed by committees of experts and administrators, using their combined judgment and experience. The second is called the "actuarial-based" method. These methods are developed from studies of real cases, whose outcomes are known when the study begins. In developing an actuarial-based method, a researcher looks for statistically valid relationships between characteristics present at the beginning of the case and the outcome being predicted. For example, cases in which the biological father is absent from the home when the case is opened might be found to have significantly higher maltreatment recurrence rates than cases where the father is present in the home when the case is opened.

Further research indicates that decisions resulting from actuarial-based risk assessment methods are typically more accurate than those resulting from consensus-based risk assessment methods. A research presentation by Dr. Dennis Wagner, National Council on Crime and Delinquency (NCCD), concluded that virtually every research study has found that actuarial techniques make more accurate predictions of human behavior than even experienced, well-trained clinicians.[3] Further, a study, conducted by Dr. Will Johnson of

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[2]Dawes, Faust, Meehl, Clinical Versus Actuarial Judgment, Science, 1989.

Johnson, Risk Assessment Research: Progress and Future Directions, Protecting Children, 1996.

Schene, Risk Assessment Roundtables, A Ten-Year Perspective, Protecting Children, 1996.

Wagner, Hull, Luttrell, Structured Decision Making in Michigan, National Roundtable on CPS Risk Assessment, 1995.

[3]Wagner, The Use of Actuarial Risk Assessment in Criminal Justice—What Can We Learn from the Experience?, National Roundtable on CPS Risk Assessment, 1993.

Alameda County, concluded that actuarial-based risk assessment methods may be considerably more accurate and efficient than consensus-based methods.[4]

The DCFS uses a consensus-based method. Because we noted several instances of inconsistent or improper usage and because research indicates that an actuarial-based method is more accurate, we believe the DCFS could improve its current method.

Table 2 compares a list of the risk factors used by the DCFS and the state of Michigan, which employs an actuarial-based assessment method. The DCFS assigns each risk factor listed in the first column a risk rating—low, medium, or high—based on the caseworker's assessment. These individual risk ratings are not, however, combined or scored in a manner which leads to an overall rating for the case.

Michigan's risk assessment method provides a statistically proven predictor of future child abuse.

The risk factors listed in the second column were developed based on a research analysis of its case files and, according to the NCCD, were statistically proven to be predictive of future child abuse. In addition, each risk factor is assigned a numerical score, which is then combined with the others to arrive at an overall risk level for the case. While some of the factors are similar to those used by the DCFS, some are different, and some are given more emphasis and specificity.

For example, the DCFS risk assessment method contains a factor (No. 7) assessing the level of the caregiver's cooperation. This factor seems vaguely worded in comparison to Michigan's two factors (Nos. 11 and 12), which use more specific wording to assess the motivation and concern of the caregivers. In addition, the Michigan risk assessment makes a distinction between the primary and secondary (if any) caregiver, and assigns "double" weight to the secondary caregiver's motivation to improve his or her parenting skills.

Michigan has further refined the risk assessment method described above, developing an overall case management system called Structured Decision Making (SDM). The SDM system uses an actuarial-based risk assessment method combined with a case management system that increases the services provided to families, based on the assessed level of risk present. A comparative study between Michigan counties that used SDM and counties that did not found that the SDM system

[4]Johnson, Accuracy, Efficiency, and Research Standards for Risk Assessment, National Roundtable on CPS Risk Assessment, 1990.

Table 2

Risk Factors Used by the L.A. County DCFS and the State of Michigan To Assess Child Abuse

DCFS Risk Factors	Michigan Risk Factors	Michigan Scoring Method
1. Child's age, physical and mental abilities	1. Current complaint is for neglect or abuse	Neglect only = 0; Includes abuse = 1
2. Severity and frequency of abuse, physical or sexual	2. Prior assigned complaints	None = 0; Abuse =1 Sexual abuse = 2; Both = 3
3. Severity, recentness, and frequency of neglect	3. Prior CPS history	None = 0; Yes = 1
4. Location of injury	4. Number of children in home	One = 0; Two or more = 1
5. School problems	5. Caretaker(s) abused as a child	No = 0; Yes = 1
6. Caretaker's physical, intellectual, or emotional abilities	6. Secondary caretaker has current substance abuse problem	No = 0; Yes = 1
7. Caretaker's level of cooperation	7. Primary or secondary caretaker employs excessive and inappropriate discipline	No = 0; Yes = 2
8. Caretaker's parenting skills and knowledge	8. Caretaker(s) has a history of domestic violence	No = 0; Yes = 1
9. Presence of a parent substitute in the home	9. Caretaker(s) is a domineering parent	No = 0; Yes = 1
10. Previous history of abuse/neglect	10. Child in the home has a developmental disability or delinquent offense history	No = 0; Yes = 1
11. Strength of family support systems	11. Secondary caretaker motivated to improve parenting skills	Yes = 0; No = 2
12. Perpetrator's access to child	12. Primary caretaker views incident less seriously than agency	No = 0; Yes = 1
13. Environmental condition of the home		
14. Stresses/crises		
15. Substance abuse drug/alcohol		
16. Other, explain		

Assigned Risk Level Using Michigan's Method:

0 - 2	**Low**
3 - 5	**Moderate**
6 - 9	**High**
10 - 16	**Intensive**

resulted in better decisions regarding case closure. Specifically, low- and medium-risk cases were closed sooner, and high-risk cases were held open longer than similar cases in counties not using the SDM system. The overall conclusion of the study was that the degree of structure and accountability offered by the SDM system appeared to substantially improve child protection in Michigan.

According to the NCCD, several states have adopted actuarial-based risk assessment methods that examined actual experience from the state's child protective services cases. In addition to Michigan, these states include Oklahoma, Rhode Island, Wisconsin, and Alaska. Each of these states received assistance from the NCCD.

The DCFS's method does not result in a standardized, overall risk rating for each case as the Michigan method does. In addition, because its risk factors seem vaguely worded and lack emphasis, it appears the DCFS's method is less likely to generate a consistent, reliable measurement of a case's risk.

Improved risk assessment methods could lead the DCFS to better decisions in child protective cases.

We believe that the efforts made by these other states indicate that specific methods exist to increase the validity and reliability of risk assessment methods in predicting potential child abuse or neglect. As discussed above, an improved risk assessment method used in another state has led to better decisions regarding how to proceed in child protective cases.

According to a June 6, 1996, letter provided us, the DCFS has been working since March 1996 to develop a new and improved risk assessment guide. The present risk assessment guide was updated in 1987. The new risk assessment guide, according to the DCFS, will consider several different risk assessment methods used by other states, including Florida, Michigan, Missouri, New York, Texas, Washington, and Wisconsin. The DCFS anticipates that its new method will add additional risk factors that have been identified in research as important to its existing risk assessment guide. (See Table 1 on page 11.) Because it is adding factors to its existing risk assessment guide, and not taking any factors away, the DCFS concluded that the validity of its new guide will not be affected.

Because the DCFS has not yet finalized its new risk assessment guide, we cannot evaluate whether it represents an improvement over the current risk assessment guide. However, because it appears that the new risk assessment guide will be developed using a consensus-based method, that is, one not based on actual research of its own cases, we question whether the DCFS can conclude that the validity of the new guide will not be affected. In order to determine the validity of a new

guide, the DCFS would have to demonstrate that its new risk assessment factors are statistically linked to the negative case outcome it is trying to predict, such as a recurrence of abuse or neglect.

Conclusion

Because the DCFS does not always follow its risk assessment policies, it has less assurance that it fully understands the conditions which place a child at risk of future maltreatment. Specifically, we found that in some cases, the DCFS did not prepare risk assessment guides or only partially completed the guides.

Moreover, the DCFS's risk assessment method does not appear to be the best available. As a result, the DCFS has less assurance that the decisions it makes concerning a child's risk of future maltreatment are accurate and reliable and that the cases most at risk receive the most intense services. We reviewed several research studies which indicate that risk assessment methods based on a study of real cases, or actuarial-based methods, are typically more accurate than the method currently used by the DCFS.

Recommendations

We recommend the DCFS investigate developing a new actuarial-based risk assessment method. Such a method should be standardized to ensure the method is applied consistently with DCFS policies and procedures and that consistent results are achieved. In addition, the DCFS should periodically evaluate the reliability and validity of the method. Finally, while the DCFS uses its current risk assessment method, it should ensure that it and its caseworkers fully understand the conditions which place a child at risk of future maltreatment and include each of the conditions in its new risk assessment guide.

Chapter 2

The Department of Children and Family Services Does Not Always Follow Its Child Safety Procedures

Chapter Summary

The Department of Children and Family Services (DCFS) does not always follow its child safety procedures established to ensure that children within its purview are adequately protected. Specifically, the DCFS does not always visit children and their parents or caregivers once per month. In addition, the DCFS did not complete criminal background checks on all adults caring for the children, nor did it always obtain timely medical assessments for detained children. Finally, the DCFS did not provide the L.A. County Superior Court (dependency court) with court-required reports on time. For two of the child safety procedures we reviewed—criminal background checks and medical assessments—the DCFS's procedures are more rigorous than those established by the California Department of Social Services.

When the DCFS does not visit children and caregivers frequently, conduct criminal background checks, or obtain timely medical assessments, it reduces its ability to monitor and ensure the safety of the children under its care. When reports are not submitted to the dependency court in a timely manner, court cases are delayed, often to another day. Such delays congest the dependency court's calendar and cause inconvenience to the children and families participating in the court's hearings.

Our review of the case files of 24 children determined that the DCFS did not comply with its own child safety procedures in several areas. Chapter 1 dealt with the problem of risk assessment. In this chapter, we will discuss the other problems noted: visitation, criminal identification investigation (CII) clearance, medical assessment, and dependency court reports. Table 3 summarizes the results of these problems.

Table 3

Summary of Problems Found During Our Review of 24 Cases

Problem	12 Death Cases	12 Random Cases	Totals
Visitation	5	3	8
Insufficient CII clearance	3	3	6
Medical assessment	2	0	2
Court reports	1	2	3
Totals	**11**	**8**	**19**

According to a February 29, 1996, letter from the DCFS Director to the L.A. County Board of Supervisors, the DCFS conducted internal investigations regarding the conduct of its case management over the 12 child deaths. A summary of the investigations' findings, attached to the February 29 letter, indicated that for 3 of the 12 death cases the DCFS had initiated disciplinary action against several employees.

Not All Children and Parents or Caregivers Were Visited at Least Once per Month

In 8 of 24 cases we reviewed, the DCFS did not visit children and their parents or caregivers at least once per month, as required by state and DCFS policy. Visitation is the face-to-face contact between a DCFS caseworker and a child, the child's parents or caregivers, or other persons designated by L.A. County or the dependency court. Visitation is one of the most important functions the DCFS engages in because it accomplishes the following tasks:

- Verifies the location of the child, monitors the safety of the child, assesses the child's well-being, and assists the child in preserving and maintaining religious and ethnic identity.

- Gathers information to assess the effectiveness of services provided to meet the child's needs and monitors the child's progress in meeting identified goals.

- Establishes and maintains a helping relationship between caseworker and child to provide continuity and a stability point for the child.

- Counsels the child as to current placement and progress.

California Department of Social Services (CDSS) regulations, as well as DCFS child safety policies, require that children be visited a minimum of one time each calendar month. However, these are only minimum requirements, and DCFS policy states that more frequent visits should be made when needed to ensure a child's safety. CDSS regulations, as well as DCFS child safety procedures, also require monthly contact with the child's parents or caregivers who have been identified within the DCFS's case plan. The case plan states the method of contact, such as telephone or face-to-face, and specifies which noncustodial parents, if any, must be contacted.

Although DCFS and state policies require at least one visit per month, this standard was not met in several cases.

The DCFS failed to satisfy the minimum visitation requirements in 8 of 24 cases we reviewed, as its caseworkers did not visit the children, designated parents, or caregivers at least once per month. Specifically, in one child death case in 1995, the DCFS failed to make face-to-face contact with the child in 9 of the 15 months preceding his death. In addition, only four visits were made in the child's father's home during this time, even though there were repeated allegations that the child was suffering physical abuse in the father's home.

In another child death case, the child was visited only four times during an 11-month period. According to the DCFS, the assigned caseworker went on leave, and the supervising caseworker did not follow established procedures to reassign the case to another worker. As a result, neither the child nor the child's mother had been visited by a DCFS caseworker for the six months preceding his death.

In still another child death case, the DCFS violated its own policy by issuing a waiver that allowed the caseworker to visit an infant once every three months, as opposed to every month. DCFS policy allows caseworkers to waive monthly visitation requirements and visit once every three months when certain conditions are met. One of these conditions is that the caseworker has visited the child in three of the last four months. However, in the case we reviewed, this condition could not possibly have been met because the child was only one month old at the time the waiver was granted. Subsequent to the caseworker's first visit with the child, no further visits occurred until over four months later.

In addition to the visitation problems discussed in the three cases above, we observed deficiencies in five other cases:

- In a child death case, the DCFS only visited the child and her caregiver two times over an eight-month period.
- In another child death case, the child was not visited by the DCFS for the two consecutive months preceding his death.
- The DCFS did not maintain adequate visitation with either the mother or the father of one child. Specifically, it did not visit the child's mother in three separate calendar months and did not visit the child's father in two separate calendar months.
- The DCFS did not visit one child or his caregivers for a five-month period and did not visit the child's mother for a seven-month period. Furthermore, the child was not visited by the DCFS for almost four months after being placed in a new foster home.
- Another child was not visited by the DCFS for over four months subsequent to the first visit after being placed with her maternal aunt. In addition, the caseworker failed to visit the child's father in four consecutive calendar months and the mother during one calendar month, even though the DCFS case plan stated they would both be visited at a minimum of once every month.

When children and parents are not visited at least once per month, the DCFS's ability to monitor child safety and assess the effectiveness of prescribed services is reduced.

When DCFS caseworkers do not visit children and their parents or caregivers at least once each month, the DCFS's ability to monitor the safety of a child is reduced. Moreover, when visits are not made, the DCFS is less able to assess the effectiveness of prescribed services or evaluate the ability of the parents or caregiver to maintain a safe home for a child.

The DCFS Does Not Always Obtain Criminal Background Checks on Caregivers

The DCFS does not always follow its policy to obtain criminal background checks on adults caring for or living with children. It either did not search or did not properly evaluate the criminal records for adults who had contact with the children in 6 of 24 cases we reviewed.

In addition to visiting children, another procedure the DCFS uses to better ensure that children are living in a safe environment is to complete a criminal background check (also called criminal identification investigation [CII] clearances). To do this, the DCFS requests the L.A. County sheriff to search for any criminal records on certain adults who have contact with the child. The caseworker then evaluates the criminal records, if any, to determine whether they adversely impact the safety of the child or the family situation.

Although state regulations do not require it, DCFS policy requires that caseworkers complete CIIs for every adult living in the home where a child is living or from which a child has been removed, or who has caregiving responsibilities for the child. CIIs are specifically required when abuse or neglect allegations are substantiated or there is reasonable suspicion in a case of unsubstantiated allegations and **one** of the following conditions is true:

- The child is under age four; or
- The child is older than age four and the allegation is for severe abuse or neglect; or
- The allegation involves a nonverbal, physically, or mentally handicapped child of any age.

When a child is removed from an offending parent's home, CIIs are required for every adult living in the home of a prospective substitute caregiver, such as a nonoffending parent or relative. CIIs are also required for any prospective day-care providers. Additionally, DCFS policy requires caseworkers to verify the relationship of a relative to the child and consider the results of criminal record review when assessing a relative for placement.

In one case reviewed, the DCFS placed a child in the care of an "aunt" without conducting a criminal check. The "aunt" allegedly killed the child and was later found not to be a relative.

In 6 of 24 cases we reviewed, the DCFS did not complete CIIs on adults caring for or living with the children. In one case, the DCFS failed to properly evaluate a CII on an alleged maternal aunt before placing a one-year-old and a two-year-old in her care. Although both the caseworkers who placed the two children stated that they obtained CIIs and the CIIs indicated "clean" records prior to the DCFS placing the children, the investigations, in fact, indicated two drug-related arrests and convictions. About two weeks later, the two-year-old child was killed, and the alleged maternal aunt was arrested for the killing. However, the DCFS never verified the identity of the children's alleged maternal aunt, who subsequently claimed to be a cousin but was later found to be only a friend the mother had met in a drug rehabilitation class. When the DCFS became

aware the alleged maternal aunt was not whom she claimed to be, it did not alert the dependency court, which had released the children to her under the impression she was their aunt.

In another case we reviewed, when the child was left with his mother, a CII was not performed on the mother's uncle, who was documented by the caseworker to live in the home, abuse alcohol, become violent, and bring friends into the home who stole from the children. When the child was subsequently placed with relatives, a CII was not completed for the grandmother, who provided care to the child.

In four other cases we reviewed, the DCFS failed to complete CIIs properly:

- In one case, the DCFS failed to obtain a CII on a caregiver prior to placing a child in the home. In this case, the caregiver was arrested for the subsequent death of the child.

- In one case, the DCFS failed to obtain a CII on one child's mother prior to leaving the child in the mother's care. When there is a substantiated allegation of neglect, as in this case, DCFS policy requires a CII be obtained on all resident adults prior to leaving the child at home.

- The DCFS did not properly obtain a CII on one child's aunt before placing the child in her care.

- The DCFS did not follow up on the possible criminal record of a child's mother prior to leaving the child in her care. The CII listed a possible criminal record, which was not on the automated system. There was no evidence in the case file to indicate the DCFS followed up by tracking down the information manually.

While obtaining any criminal information for parents, caregivers, or other adults in a child's home does not in itself protect the child, not following this DCFS procedure does reduce its ability to evaluate the suitability of parents or caregivers to provide a safe and caring home environment. Additionally, the risk to the child's well-being is increased when the DCFS places the child with adults whose backgrounds are unknown.

The DCFS Did Not Obtain Medical Assessments for High-Risk Children

In 2 of 24 cases we reviewed, the DCFS did not obtain medical examinations within required time limits or immediate medical assessments to address injuries to a child when it was uncertain whether the injuries were caused by abuse or neglect.

The DCFS provides medical care for the children it serves through the Child Health and Disability Prevention (CHDP) Program. The DCFS requires CHDP medical examinations on all children subsequent to placement in out-of-home care. These medical examinations are given to detect any medical problems and to assess the child's overall health.

In two cases reviewed, the DCFS did not follow its own procedures for required medical examinations and treatment of injuries for children.

Although state regulations require medical examinations within 30 days after placement, the DCFS policy further requires that infants (under two years of age) and certain high-risk children receive medical examinations within three days after placement. Additionally, DCFS policy states that a medical assessment is required when the caseworker is unclear as to the cause of injuries. Finally, DCFS policy also requires, with certain exceptions, that medical assessments be completed on all child victims of physical abuse, aged four or under. Exceptions are granted when abuse allegations are patently unfounded, when the caseworker can verify that the injury was accidental, or when a physical examination has already been done and the physician will share the results of the examination.

The DCFS is required to inform families with eligible children about the CHDP Program, assist with referral and transportation to providers, and follow up to ensure that necessary diagnostic and treatment services are provided. If caregivers are not eligible for or do not wish to utilize the CHDP Program, they may obtain an equivalent examination from a non-CHDP physician.

In one of the two cases where medical assessment procedures were not followed, a one-year-old did not receive a medical examination until 18 days after placement with a caregiver. Although it met state regulations that require medical examinations within 30 days, the DCFS's own policy required an examination within three days. When the caseworker subsequently placed the child's sibling in the same household, he noticed bruises in different stages of healing on the one-year-old's face and head. When questioned about the bruises, the caregiver stated she had no idea how they occurred, leaving the caseworker unclear as to the cause of injuries. The caseworker noted that the one-year-old was

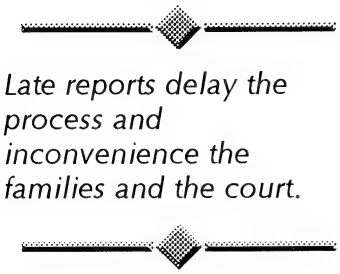
generally unresponsive and told the caregiver to obtain immediate medical attention for the child; however, the caseworker did not follow up to ensure it was provided. Furthermore, a medical examination conducted seven days later did not address the bruises and marks observed on the one-year-old, nor was there any evidence of follow-up by the caseworker. The caregiver was later arrested and charged with the child's sibling's death.

In the other case, a ten-month-old baby was placed in a home and did not receive a medical examination for over four months, even though DCFS policy requires children under two years of age to receive a medical examination within three days of placement. According to DCFS staff, the child was taken to a doctor on the date of placement but had chicken pox, so the doctor sent the baby home unexamined. DCFS staff further explained that a subsequent examination was performed; however, we found no evidence within the case file to support this explanation. Furthermore, although we requested DCFS staff to provide us with any documents to support their explanation, we have not received any such evidence.

When the DCFS does not follow its own procedures regarding required medical examinations and addressing injuries to children, it misses opportunities to identify potential abuse that may not be apparent or may lose evidence that could prevent future harm to the child. Further, the DCFS reduces its ability to monitor the overall health and adequately ensure the safety of children.

The DCFS's Reports to the Dependency Court Were Late

The judicial officer and the various attorneys who take part in the hearings conducted in the dependency court rely on information provided by the DCFS. California Rules of Court requires the DCFS to prepare certain reports that include information relevant to the disposition of the case and its recommendations. These reports must be submitted to the dependency court at least 48 hours prior to the scheduled dependency court hearing.



Late reports delay the process and inconvenience the families and the court.

Three of the case reports we reviewed were not submitted to the dependency court on time. When reports are not submitted on time, the judicial officer and attorneys who are involved with the specific hearing may not have sufficient time to assess the information within the report and, therefore, the hearing may need to be continued to a later date. These continuances not only congest the dependency court's calendar but also cause tremendous inconvenience for the participants of the hearings, who make arrangements to appear, wait through the day for their hearing, and then receive instructions to come back another day.

Conclusion

Our review of 24 children's case files found the DCFS does not always follow its safety procedures established to protect children. For example, not all children and their parents or caregivers were visited once per month, as required by state and DCFS policy. In addition, the DCFS did not always obtain criminal background checks on adults caring for or living with children. Moreover, it did not obtain timely medical assessment for all high-risk children or submit court reports 48 hours before hearings, as required.

When the DCFS does not visit children and caregivers, conduct criminal background checks, or obtain timely medical assessments, it reduces its ability to monitor and ensure the safety of the children under its care. Further, when reports are not submitted to the dependency court in a timely manner, cases are delayed, often to another day. Such delays congest the court calendar and cause inconvenience to the children and families participating in the court hearings.

Recommendations

To protect the safety of the children who are referred to it because of suspected abuse or neglect, the DCFS should follow its child safety policies and procedures. Specifically, it should take the following steps:

- Ensure that its caseworkers visit children and their parents or caregivers a minimum of once each calendar month. If safety or risk conditions indicate, the DCFS should consider more frequent visits.

- Follow its procedures and obtain CII clearances when required.

- Ensure that medical examinations are obtained within required time limits and that complete and appropriate medical attention is obtained in a timely manner when injuries to children are noted.

- Submit its completed reports to the dependency court at least 48 hours prior to the hearing date.

We conducted this review under the authority vested in the state auditor by Section 8543 et seq. of the California Government Code and according to generally accepted governmental auditing standards. We limited our review to those areas specified in the audit scope section of this report.

Respectfully submitted,

KURT R. SJOBERG
State Auditor

Date: October 23, 1996

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COUNTY OF LOS ANGELES
DEPARTMENT OF CHILDREN AND FAMILY SERVICES

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PETER DIGRE
Director

October 16, 1996

Kurt R. Sjoberg, State Auditor
Bureau of State Audits
660 J. Street, Suite 300
Sacramento, CA 95814

Dear Mr. Sjoberg:

We have enclosed our response to your October 4, 1996 draft report of the Los Angeles County Department of Children and Family Services and revisions to the draft faxed by your staff on October 15, 1996.

Very truly yours,

Peter Digre

Peter Digre, Director

PD:gg

Enclosures

RESPONSE TO CALIFORNIA STATE AUDITOR REPORT
EXIT CONFERENCE: OCTOBER 8, 1996

THE CALIFORNIA STATE AUDITOR REPORT FAILS TO ADDRESS THE IMPACT OF JUDICIAL DECISIONS WHICH ARE CONTRARY TO DCFS RECOMMENDATIONS ON CHILD SAFETY ISSUES IN DEPENDENCY CASES

The State Auditor's report expressly admits that it focused its "audit efforts and recommendations on the DCFS because the dependency court system relies almost exclusively on information provided by the DCFS..." This statement is inaccurate and demonstrates **the fundamental failure in the scope and direction of the State Auditor's inquiry and conclusions.** (1)*

The dependency court system is an adversarial one which relies on information presented by parents' attorneys, child attorneys, court-appointed therapists and witnesses as well as information provided by DCFS. While it is accurate that the dependency court accepts DCFS' decisions about 97% of the time, it is the 3% of the cases in which DCFS' recommendations are not accepted (about 300 cases per month) which may involve the most serious allegations and potential impact on child safety. **The State Auditor's failure to even consider or to address the more serious cases and the cause and effect relationships on child safety is the most glaring deficiency in its report.** (2) (3)

For example, in one case, the dependency court ordered, against DCFS' strong recommendation, unmonitored visitation by a mother with her seven-month old infant who had sustained, in a three-week period, severe and extensive injuries which were described in the medical report as including three fractured bones in her arm and multiple bruises to her face and body inflicted by the father. According to the examining physician, it was "impossible" for the mother not to have been aware of the swollen limbs, discoloration from bruises and "severe pain" of the baby. DCFS was successful in convincing the appellate court in this case that the court had abused its judicial discretion and that the order had placed the child "at risk for additional significant injury," and constitutes the potential of a threat to her life. The appellate court thus reversed the lower court decision.

In another case, the court allowed a father who had already molested his daughter twice (once during a monitored visit) further monitored visits and dismissed a petition on behalf of this child and a sibling indicating that the father was not a danger to these children. The court denied the DCFS request for an expedited rehearing and further abuse occurred. DCFS was successful in obtaining an appellate court order expressly prohibiting the court from allowing any further such visits pending further order of the appellate court.

While DCFS was successful in these two cases, it is common knowledge in the judicial system that the securing of a reversal of the trial courts' judicial decision or order based on the exercise of judicial discretion is extremely difficult. Thus, it must be accepted that regardless of DCFS' efforts in seeking appellate review, the appellate court routinely affirms orders and decisions based on judicial discretion, absent exceptional circumstances and facts.

*The California State Auditor's comments on this response begin on page 41.

DCFS is prepared to provide further examples if the Legislature wishes to order the Auditor to expand the scope of its report which DCFS believes is directly inconsistent with the original intent of the State Legislature in ordering the investigation. (4)

DCFS' social workers provide the courts with their best professional judgment in formulating their recommendations on issues of child safety. Their judgment is a human one just as is the decision of the judicial officer charged with the ultimate responsibility of deciding child safety issues based on conflicting views of the parties involved in the proceedings. While it must be the goal of everyone to prevent child abuse, mistakes can be made. DCFS, however, is only one of several adversarial participants whose recommendations are factored into the ultimate judicial decision on the safety of a child.

DCFS contends that an appropriate scope of inquiry must consider all aspects and parties in the adversarial dependency system and cannot focus exclusively on DCFS. In fact, DCFS believes that the intent of ordering the State Auditor's inquiry, in the first instance, was designed to determine the circumstances which resulted in child endangerment such as occurred in the Lance H. case. Such an inquiry cannot focus exclusively on DCFS as other adversarial participants and the court were integral to the decision in that case and all cases. (5)

THE CALIFORNIA STATE AUDITOR REPORT IS INCONSISTENT WITH FEDERAL AND STATE LAW AND REGULATIONS

DCFS appreciates the State Auditor's recognition that DCFS has adopted and implemented many child safety measures (many more than addressed in this report) that go **far** beyond the mandates of federal and state law and regulation because we believe that these higher standards are essential to our efforts to protect children. The California State Auditor provides the weight of authority to the policies employed by LADCFS over and above state mandates.

Specifically in this regard, the California State Auditor draws conclusions based on areas of risk assessment, clearances of the State's Criminal Identification Investigation (CII) Index and medical examinations of high-risk children within three days of placement, none of which are regulated by the Federal or State governments (i.e., Federal and State law and regulations are totally silent on risk assessment and on CII clearances for related caretakers, parents and other adults with access to the child and regulations set a 30-day, not a 3-day, standard for medical review).

By citing such unregulated areas as "best practice" standards, the California State Auditor's report may open the door to legal challenge, i.e., the California State Auditor in its role as a State agency and, more specifically as the official audit arm of the California State Legislature, may be interpreted as establishing new standards which a variety of child advocacy groups and private individuals may use to bring suit against the State and any of the other 57 counties for not requiring and/or complying with these same standards. In short, the State is admitting that the minimum State standards are inadequate to protect children. We applaud this recognition but we caution the State to go through the formal rule-making process so that counties are not taken unaware by such potential legal actions. (6)

If the people of California wish to require the above child safety measures through the statute/regulatory process, LADCFS will enthusiastically support this enhancement; as noted, we have already adopted such measures.

THE CALIFORNIA STATE AUDITOR REPORT HAS NO STATISTICAL VALIDITY

The State Auditor used as a basis for their conclusions a random sample of 12 cases selected from a data base of 70,000 active cases. They compiled the findings from these 12 cases with the findings that LADCFS had already made (and reported to the Los Angeles Board of Supervisors) on 12 child homicides which occurred in 1995 and which are not, therefore, even part of the same active-case data base. **These 24 cases do not represent a reliable sample, the findings proceeding from the cases have no statistical reliability and, thus, the many conclusions extrapolated from these cases and stated throughout this report, beginning with its title, are unfounded.** DCFS and the California Department of Social Services have, on the other hand, statistically valid data on thousands of sample cases on all the mandated elements cited by the California State Auditor in this report and DCFS has further statistically valid data on thousands of sample cases which reflect the extra, non-regulated child-safety elements (with the one exception being risk assessment) in the report. **The existence of these data was made known to the State Auditors and DCFS reports were made available to the auditors. It is of further note, therefore, that none of the statistically reliable data was mentioned in this report and only the anecdotal picture based on 12 random cases and 12 more of our cases with the worst possible result (i.e., homicide by caretaker) were cited.** In regard to the child deaths, it must be further pointed out that social workers, social work supervisors and managers were disciplined and, in some cases, discharged from County service for their failure to adhere to requirements in some of these cases.

(7) (8) (9)

CDSS COMPLIANCE STATISTICS SHOW LOS ANGELES, ONE OF ONLY THREE COUNTIES, IN FULL COMPLIANCE WITH STATE CHILD WELFARE REGULATIONS

Attachment I shows, based on CDSS' statistically-reliable audits, three counties (of the 32 counties CDSS has audited thus far) in overall compliance with child welfare regulations:
Los Angeles, Kern and Yuba.

Relatedly, the "Timothy J" lawsuit was brought by public-interest attorneys against Los Angeles County in 1987 for failure to visit children. An intrinsic part of the settlement, which was concluded in 1993, was that DCFS would audit according to guidelines and results validated by CDSS and plaintiffs' attorneys. During the two years immediately preceding the settlement agreement, CDSS had also begun regular reviews of counties for compliance with child visitation and other elements of child welfare regulations. It is these reviews which are cited above and shown in Attachment I; Attachments II through V also depict LADCFS performance in visitation, medical assessment and CII clearances with that of other counties audited by CDSS. Please note that during 1993/94, CDSS changed their reporting methodology to show only whether audit elements were above or below the 90% compliance level; thus, while Attachment II shows visitation percentage comparisons with other counties, Attachment III shows visitation for the counties CDSS audited in 1994 through 1996 only as above or below the 90% compliance level

for visitation. The conclusion is that of the 32 counties audited by CDSS in the five-year period from June 1991 through July 1996, Los Angeles DCFS is in the 33% of the counties found to be in visitation compliance and one of only three counties in overall compliance with state regulations.

The State Auditor draws conclusions from 24 cases in visitation, medical assessments, criminal background checks and timeliness of court reports. Comparison of DCFS' and CDSS' statistically reliable findings with the State California Auditor's anecdotal conclusions is noted below:

STATISTICAL COMPLIANCE COMPARISONS			
	CDSS	DCFS	California State Auditors
Year	1992/93	1/95 - 7/96	1996
Sample Size (# of Cases)	540	14,841	24
Random Draw	YES	YES	12 of 24
Confidence Level	95%	*95%	NONE
Reliability Factor	3%	*3%	NONE
* Note that the confidence level and reliability factor for DCFS reviews are based on the monthly audits of approximately 750 cases drawn randomly each month. The 14,841 cases represents the aggregate sample of 19 months (1/95 - 7/96) which actually reduces the reliability to less than 1% variation (plus or minus) from the percentage findings.			

Visitation Compliance	90%	92%	^83%
^ Based on the 12 cases chosen at random, the California State Auditors found two out of 12 cases with a child visitation deficiency, which is 83% based on those 12 cases, but has no reliability when extrapolated to the entire population.			

Medical Compliance	90%	90%	**96%
** Based on state criteria, California State Auditors found 96% in medical compliance and using LADCFS local policies found 92% compliance.			

Criminal Background Check	@	90%	75%
@ The state does not require or fund CII checks for parents or relatives.			

Court Report Timeliness	90%	~90%	88%
Court Continuances	~ Court continuances due to late court reports average 2% of the total continuance rate on a monthly basis.		

TOP EXPERT DISAGREES WITH RISK ASSESSMENT PROTOCOL ADVOCATED BY CALIFORNIA STATE AUDITOR

The State Auditor's report expends a great deal of narrative in discussing risk assessment in terms of a preferred protocol. **Again, this is one of the areas in which there is no protocol specified in federal/state law or regulation. The report, however, actually notes that in all 24 cases, the Los Angeles protocol was followed**, although the Auditor points out that one risk

(10)

assessment form was not signed by the social worker and they go on to question the judgment factor in five other cases, three of these cases being those in which the child died.

In terms of the State Auditor's opinion and recommendation for the actuarial-based "Michigan Model" assessment guide, as opposed to a consensus-based model, we question both the credentials of the California State Auditor and the one "research" source to which they briefly allude in their report as being credible in making such a determination. (11)

In actuality, we could find no research which has compared and drawn conclusions as to the two models, although a three-year study has recently begun in Madison, Wisconsin to test the premise regarding the quantified decision-making of the actuarial model. In its new assessment protocol, a copy of which was provided to the State Auditors, DCFS has incorporated all the source elements of the Michigan model but not the decision-making methodology of the Michigan model. In the absence of persuasive research to the contrary, DCFS has chosen to base decisions on professional analysis as opposed to quantification analysis, which is the choice of 75% of the states in this country and numerous professionals in the field, including Dr. Michael Wald, Stanford law professor, a principle author of SB-14 (implementing legislation for PL 96-272 and consultant on its several revisions) and recognized expert in public child welfare policy. Dr. Wald says (in the treatise attached) "INSTRUMENTS SHOULD BE USED AS A MEANS OF IMPROVING CLINICAL JUDGMENT, NOT AS AN ACTUARIAL DEVICE." (12)*

DCFS is willing to change its model if future research should prove persuasive; DCFS is also looking forward to participating with the task force now being assembled by CDSS and will certainly abide by the State-defined model, once it is finalized. **However, the State model is projected to be a four-year development and implementation project and will therefore not be implemented until the year 2000.** From this perspective, DCFS intends to implement its new model, as described above, within the next few months.

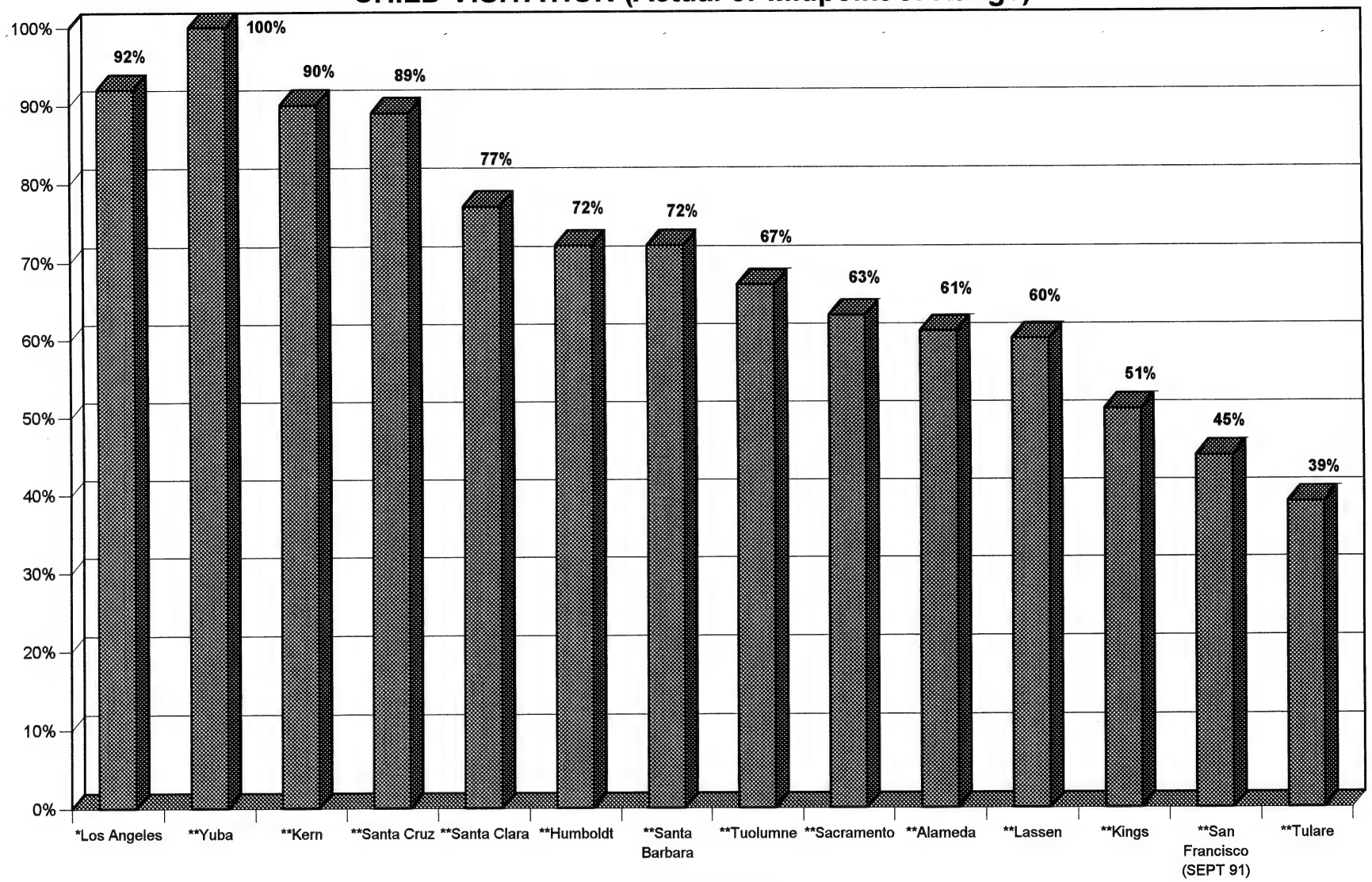
PD:gg

*A copy of the document *Risk Assessment: The Emperor's New Clothes?* is available for review in the California State Auditor's office.

TOTAL COUNTY
CHILD WELFARE COMPLIANCE

PASS	FAIL	NOT REVIEWED YET
Los Angeles	Alameda	Amador
Yuba	Alpine	Calaveras
Kern	Butte	El Dorado
	Colusa	Fresno
	Contra Costa	Glenn
	Del Norte	Inyo
	Humboldt	Marin
	Imperial	Mariposa
	Kings	Mendocino
	Lake	Merced
	Lassen	Modoc
	Madera	Mono
	Nevada	Monterey
	Plumas	Napa
	Riverside	Orange
	Sacramento	Placer
	San Benito	San Joaquin
	San Bernadino	Shasta
	San Diego	Sierra
	San Francisco (94/95)	Siskiyou
	San Luis Obispo	Solano
	San Mateo	Sonoma
	Santa Barbara	Stanislaus
	Santa Clara	Tehama
	Santa Cruz	Trinity
	Sutter	Ventura
	Tulare	Yolo
	Tuolumne	

CDSS COMPLIANCE REVIEWS
CHILD VISITATION (Actual or Midpoint of Range)



COUNTIES

*** Actual CDSS '92 and averaged actual through 9/96**

****Midpoint of Range Projected in CDSS Reviews During 1991 and 1992**

1994-95 CWS PROGRAM REVIEWS
CHILD VISITATION

*

COUNTY	PASS (90% OR ABOVE)	FAIL (UNDER 90%)
Imperial		X
Contra Costa		X
Colusa		X
San Mateo	X	
San Benito		X
San Bernadino	X	
Riverside	X	
Nevada	X	
Butte		X
San Luis Obispo		X
Sutter		X
Lake		X
Del Norte		X
San Diego	X	
San Francisco	X	
Alpine	X	
Plumas		X
Madera	X	
TOTAL	8	10

*** IN THE 94/95 TIMEFRAME, THE STATE STOPPED PUBLISHING ACTUAL PERCENTAGES AND PUBLISHED FINDINGS ONLY AS 90% OR ABOVE (PASS) AND UNDER 90% (FAIL).**

Attachment IV

MEDICAL ASSESSMENT COMPLIANCE
(OF COUNTIES AUDITED)

Compliance 90% or Above	Compliance Below 90%
Los Angeles	Tuolumne
Humboldt	Kings
Lassen	Sacramento
San Bernadino	Santa Clara
Nevada	San Francisco
San Francisco (3rd review)	Alameda
Plumas	Santa Barbara
Madera	Santa Cruz
	Kern
	Imperial
	Contra Costa
	Colusa
	San Mateo
	San Benito
	Riverside
	Butte
	San Luis Obispo
	Sutter
	Lake
	Del Norte
	San Diego
	Alpine

CII CLEARANCES: RESULTS

Results at 90% or Above	Results Below 90% or Unknown * Note: California does not require or audit for this element.	
Los Angeles County	Alameda	Tulare
	Alpine	Toulumne
	Amador	Ventura
	Butte	Yolo
	Calaveras	Yuba
	Colusa	
	Contra Costa	
	Del Norte	
	El Dorado	
	Fresno	
	Glenn	
	Humboldt	
	Imperial	
	Inyo	
	Kern	
	Kings	
	Lake	
	Lassen	
	Madera	
	Marin	
	Mariposa	
	Mendocino	
	Merced	
	Modoc	
	Mono	
	Monterey	
	Napa	
	Nevada	
	Orange	
	Placer	
	Plumas	
	Riverside	
	Sacremento	
	San Benito	
	San Bernadino	
	San Diego	
	San Francisco	
	San Joaquin	
	San Luis Obispo	
	San Mateo	
	Santa Barbara	
	Santa Clara	
	Santa Cruz	
	Shasta	
	Sierra	
	Siskiyou	
	Solano	
	Sonoma	
	Stanislaus	
	Sutter	
	Tehama	
	Trinity	

Comments

California State Auditor's Comments on the Response From the Department of Children and Family Services

To provide clarity and perspective, we are commenting on the Department of Children and Family Services' (DCFS) response to our audit report. The numbers correspond to the numbers we have placed in the response.

(1) The DCFS has taken this statement out of context. The Joint Legislative Audit Committee requested that our office perform this audit to review the facts surrounding one child death case in 1995. We initially expanded our review to include the 12 Los Angeles County (L.A. County) child death cases that occurred in 1995 and subsequently added 12 cases selected at random. During our preliminary fieldwork, we did, in fact, look at the entire Juvenile Division of the L.A. County Superior Court (dependency court) system, including the courts, attorneys, and the DCFS.

The DCFS suggests that our review should have placed greater emphasis on the operation of the dependency court. During our preliminary fieldwork, we learned that the dependency court, in making its decisions, relies heavily on information provided by the DCFS. Moreover, in about 98 percent of all cases, the DCFS's recommendations are supported by the court. When the decision of the court does not support a DCFS recommendation, it is called an adverse decision. Only 1 of the 12 death cases that we reviewed involved an adverse decision. In that one case, the DCFS did not exhaust the legal remedies available to overturn the adverse decision. Furthermore, the DCFS only sought dependency court action for 6 of the 12 death cases. It was this information, coupled with the fact that in about 98 percent of all cases the DCFS's recommendations are supported by the court, that led us to conclude that available audit evidence indicated we should focus our review on the DCFS.

The scope and methodology section of our report was expanded to fully explain the audit work performed.

(2) On page 5 of our report, we note that the dependency court agrees with the DCFS's recommendations in approximately 98 percent of court hearings. Specifically, adverse decisions

totaled 546 (.4 percent) out of 153,700 hearings in 1995 and 1,557 (1.6 percent) out of 96,100 hearings for the first seven months of 1996.

(3) We disagree with this statement. As noted above, we reviewed 12 death cases—cases we would consider to be very serious. In addition, pages 5 and 6 of our report describe adverse decisions and the various legal remedies available to the DCFS and its legal representative, the county counsel. Although we sought specific information from the county counsel that would illustrate how frequently and effectively they used these legal remedies, at the time of the completion of our report, the county counsel had not provided us the requested information. As a result, it is unclear how often the DCFS actually pursues the legal remedies available when an adverse decision occurs, or how successful such efforts are.

(4) We believe that the scope of our audit fully met the intent of the Joint Legislative Audit Committee. As noted in our Comment 1 above, our audit did consider the entire dependency court system.

(5) As noted in our Comment 1 above, we did review all aspects of the dependency court system during our initial review of the death cases. Included in our review was the individual case mentioned by the DCFS. In that specific case, we believe that circumstances indicated that we focus our attention on the actions taken by the DCFS.

We reviewed the case specified by the DCFS as part of our review of the 12 death cases. We believe that it would be inappropriate to discuss the specific details of our review because of the confidential nature of the case records. We did, however, note lapses in the DCFS's child safety procedures for that case, and our report includes our findings—combined with our findings for the other cases we reviewed. We also find it troubling that the DCFS did not seek an emergency appeal when the dependency court's decision conflicted with the DCFS's recommendations in this case.

(6) Our recommendations should not be interpreted as establishing new standards. We reviewed the DCFS's compliance with its own standards. As the DCFS notes in its response, its own policies concerning criminal background checks and medical examinations for high-risk children exceed state and federal regulations. By establishing such higher standards, and spending public monies to implement them, we believe that it is appropriate to measure the DCFS's compliance against those standards.

(7) Our conclusions are based on the results of our review of 24 cases, and we believe that our conclusions accurately reflect our findings. As mentioned in our Comment 1 above, the Joint Legislative Audit Committee requested that our office review one specific case. If we had reported findings for only one case, we would have violated the confidential and sensitive nature of the case. As a result, we decided to include in our analysis the rest of L.A. County child death cases that occurred in 1995 and for which the DCFS had contact with the children or parents. Furthermore, because we anticipated that the 12 child death cases might contain more instances of noncompliance than other cases, we decided to include 12 additional cases selected at random to provide balance.

(8) While we were aware of the DCFS's internal quality control reviews, due to the specific scope of our review, as discussed in Comment 6 above, we believe that it was most appropriate to conduct an independent review of cases we selected. We do find it troubling that, despite their claim of a 90 percent compliance rate (see page 4 of the DCFS's response), we were able to find so many instances of noncompliance in our sample of 24 cases.

(9) Text changed.

(10) We disagree with this statement. Our report, in Chapter 1, notes that 25 percent (6 of 24) of the cases we reviewed did not follow the DCFS's risk assessment policies.

(11) We cite several research sources in our report. We believe that the findings presented by these researchers support the merit of actuarial-based risk assessment models. Although dissenting opinions may exist, it appears that the most current research supports actuarial-based models.

(12) The DCFS refers to an article entitled *Risk Assessment: The Emperor's New Clothes?* that was published in 1990 and was based on a presentation made in 1989. We believe that the research cited in our report reflects more recent studies and may, in fact, have addressed some of the author's concerns regarding a general lack of empirical research for consensus-based risk assessment models.

The Superior Court
LOS ANGELES, CALIFORNIA 90012
CHAMBERS OF
GARY KLAUSNER
PRESIDING JUDGE

TELEPHONE
(213) 974-5562

October 8, 1996

Mr. Kurt R. Sjoberg
State Auditor
CALIFORNIA STATE AUDITOR
660 J Street, Suite 300
Sacramento, California 95814

Dear Mr. Sjoberg:

On behalf of the Los Angeles Superior Court, I would like to thank you for the opportunity to prepare a written response to the State Auditor's Report on the Department of Children and Family Services.

The Court has reviewed the report and believes it to be both thorough and accurate. The Court has no additional comments or information to provide.

I would like to thank you again for taking the time and effort to investigate and make recommendations on the Dependency System in Los Angeles County.

Sincerely,

Gary Klausner
Presiding Judge

GK:gp
Auditor.Ltr

c: Presiding Judge Richard Montes, Juvenile Court

cc: Members of the Legislature
Office of the Lieutenant Governor
Attorney General
State Controller
Legislative Analyst
Assembly Office of Research
Senate Office of Research
Assembly Majority/Minority Consultants
Senate Majority/Minority Consultants
Capitol Press Corps